

Transitioning From Tube Feeding To Oral Diet

Client Name: _____ **#:** _____ **Initiated by:** _____ **Date:** _____

Screen
Nutrition Screen diagnosis: Transition From Enteral Tube Feeding To Oral Intake
Signed: _____ Date: _____

Assess (Check any/all)
 Oral feeding readiness
 Dehydration
 Poor strength
Weight/BMI
 Weight change >3 lb/wk, >5%/mo, or >10%/6 mo
 BMI <20
 BMI >27
Poor Oral Intake Symptoms
 Lack of appetite Decreased ability to chew/swallow
 Complex diet order Nausea
 Vomiting Depression/anxiety
 Signed: _____ Date: _____

High Risk Interventions (Check any/all)
 4 Ways To Improve Nutrition provided and explained
 Food Record provided and explained
 Fluid intake stressed
Obtain Dr. orders as needed:
 RD referral for home visit/nutrient analysis
 Speech Language Pathologist (SLP) referral for oral feeding readiness/ problems
 Tube feeding
 Monitor weight q: _____
 Monitor I & O q: _____
 BID/TID supplements
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Assess Response (Check any/all)
 Further weight loss
 Continued dehydration
 Continued loss of strength
 Cannot tolerate oral feeding
 Exhibiting Poor Oral Intake Symptoms
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Outcomes Not Achieved
Reassess/evaluate need for further enteral feeding. Document on Nutrition Variance Tracking form.

Goals (check any/all):
 Maintain or improve nutritional status in _____ (goal time).
 Increase weight by _____ lb in _____ (goal time).
 Successful transition from enteral tube feeding in _____ (goal time).
 Maintain or improve hydration status in _____ (goal time).
 Increase oral intake to meet nutritional needs in _____ (goal time).

Moderate Risk Interventions (Check any/all)
 4 Ways To Improve Nutrition provided and explained
 Food Record provided and explained
 Fluid intake discussed and encouraged
Obtain Dr. orders as needed:
 RD chart consult
 SLP chart consult
 Monitor weight q: _____
 BID/TID supplements
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Assess Response (Check any/all)
 Further weight loss
 Dehydration
 Poor strength
 Cannot tolerate oral feeding
 Exhibiting Poor Oral Intake Symptoms
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Outcomes Achieved
 Oral diet tolerated
 Weight gained
 Hydration status maintained or improved
 Absence of Poor Oral Intake Symptoms
 Strength maintained or improved
 Other: _____
 (See notes for documentation.)
 Repeat Nutrition Risk Screen in _____ days
 Signed: _____ Date: _____

Outcomes Achieved
 Oral diet tolerated
 Weight gained
 Hydration status maintained or improved
 Absence of Poor Oral Intake Symptoms
 Strength maintained or improved
 Other: _____
 (See notes for documentation.)
 Repeat Nutrition Risk Screen in _____ days
 Signed: _____ Date: _____

